

**OFFICE OF THE PUBLIC ADVOCATE**  
**REVIEW OF DISABILITY LEGISLATION**

**Table of Contents**

Chapter 3 The new legislation for disability .....	2
Principles of the legislation.....	2
Chapter 4 Building inclusive communities.....	3
Office of Disability .....	3
Disability Action Plans .....	3
Disability Advisory Council .....	4
Chapter 5. Disability services and supports.....	5
The definition of disability.....	5
Determining disability .....	5
Planning .....	6
Tenancy rights for people with a disability in community residential units.....	7
Protecting privacy and managing information.....	8
Money held on behalf of people with a disability.....	9
Chapter 6. Accountability of disability services and supports.....	10
Provision of information to support users.....	10
Improving the quality of disability services and supports .....	10
Disability Complaints System.....	11
Community Visitors.....	12
Reviewable decisions.....	13
Chapter 7. Restrictive Interventions .....	14
The Office of the Senior Clinician.....	14
Restraint and seclusion in the new legislation .....	15
Compulsory Treatment .....	17

## **Chapter 3 The new legislation for disability**

### *Principles of the legislation*

#### **Recommendation 3**

*3. The legislation should contain both broad principles and principles specific to the provision of disability services and supports, drawn from the State Disability Plan, the Intellectually Disabled Persons' Services Act and the Disability Services Act.*

The Public Advocate supports this recommendation.

In relation to the proposed principles the expression “so far as is practicable” in the first principle is ambiguous. It could be read as limiting the exercise of human rights because of disability rather than people with a disability’s obligation to exercise their responsibilities so far as is practicable because of their disability.

## Chapter 4 Building inclusive communities

### *Office of Disability*

#### **Recommendation 4**

*4. An Office of Disability should be established to provide a more strategic, whole-of-government approach to supporting the needs and aspirations of people with a disability.*

In order for this new Office to achieve its stated objective “to drive a whole-of-government and whole-of-community approach to disability services and supports” (p.2), the Office of Disability must be adequately resourced and empowered. It must have a commitment to being accountable, independent, transparent and inclusive of all people with disabilities.

The Office of Disability should be placed within the Department of Victorian Communities to enable it to meet its strategic objective and to emphasise the fact that the rights and needs of people with a disability is a *community responsibility*. To ensure its accountability to the whole of the community, the Office of Disability should report annually to the Victorian Parliament on its activities.

### *Disability Action Plans*

#### **Recommendation 6**

*6. Disability action plans should be consistent with requirements of the Disability Discrimination Act (Cwlth).*

In developing disability action plans which are consistent with the *Disability Discrimination Act (1992) (Cwlth)* these plans should use the definition of disability from the *Disability Discrimination Act (1992) (Cwlth)*, which includes mental illness.

#### **Recommendation 7**

*7. Government departments, local governments and prescribed statutory corporations and statutory authorities should be required to report on the implementation of their disability action plans in annual reports.*

The Public Advocate supports the development and implementation of disability action plans across all state government departments and authorities. These plans should not be limited by the definition of disability used in this legislation, but rather should include people with a mental illness and personality disorders and to be consistent with the definition of disability in the *Disability Discrimination Act (1992)*.

The disability action plan reports should be accessible from one central point as well as through individual bodies' annual reports to enable ease of access, increased transparency and accountability. Perhaps the clearinghouse for this information should be the Office of Disability.

## *Disability Advisory Council*

### **Recommendations 8 and 9**

*8. The legislation should provide for a Disability Advisory Council and set out its functions.*

*9. The legislation should set out the terms of membership for the Disability Advisory Council.*

The Disability Advisory Council (DAC), its functions and membership should be set out in legislation. There is no information in the *Report of Recommendations* paper regarding the representative nature of the DAC. The membership of the DAC should be consumer focussed, made up of primarily of people with disabilities and with representation of carer groups. The paper does not set out how the DAC consults with people and consideration should be given to making formal links to local government disability advisory groups and councils.

The DAC should be based in the Ministry of Victorian Communities rather than DHS as its role is across all of government and to foster attitudinal shifts in the Victorian community.

## Chapter 5. Disability services and supports

### *The definition of disability*

#### **Recommendation 10**

*The legislation should contain the following definition of disability for the purpose of determining who may access disability services and supports under the Act:*

*‘Disability’ means a disability attributable to an intellectual, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which is permanent or likely to be permanent and results in substantially reduced capacity in at least one of the following:*

- self-care or management*
- mobility*
- communication*

*requiring significant ongoing or long term episodic support and which is unrelated to ageing.*

The Public Advocate notes that the proposed definition will not include people who have a personality disorder. The provisions of the Mental Health Act provide scant licence to provide services to this group of people. The Public Advocate considers that this group cannot be omitted from disability services.

The list of “substantially reduced capacities” does not include those whose disability results in their inability to develop or maintain relationships. Where a person who has a disability does not seek such relationships they will not seek services. Where a person does seek relationships but is unable to develop or sustain them, this is an important area of human need that should be acknowledged and which may benefit from service intervention.

The separation of services for people who have a psychiatric disability from the operation of this Act must not result in the failure to provide services for those with dual or multiple disabilities, as occurs too frequently now.

### *Determining disability*

#### **Recommendation 12 & 13**

*12. The criteria and process for determining whether a person has a disability within the meaning of the Act should be contained in Department of Human Services policy.*

*13. A decision that a person does not have a disability within the meaning of the Act should be reviewable.*

The Public Advocate supports recommendation 12, but is conscious of how multifarious are the disabilities that affect people. In permitting the right of a person to seek review of decisions that they do not have a disability, it must be clear that a review may lead to a re-evaluation of the policy and guidelines and not simply whether the person does not meet the policy and guidelines as written.

#### **Recommendation 14**

*14. The legislation should require the criteria for priority of access to:*

- *be fair and equitable*
- *take into account relative need*
- *be published and made accessible to people with a disability, their parents, families and carers.*

The concept of relative need is problematic. Whilst it is recognized that there are limited resources to provide services for people who have a disability, the criteria for making priorities should be set out in policy. Further, each year the Department of Human Services should report to the Victorian Parliament as to what services people who have a disability have sought for which there have been a lack of resources to provide. This will assist in the development of a more reliable understanding of unmet need. The requirement to report to parliament should be a legislated requirement.

### ***Planning***

The Public Advocate welcomes the continuation of individual plans for people who have an intellectual disability and the extension of planning for people who have other disabilities. The mechanism for reviewing general service plans and individual program plans in the current *Intellectually Disabled Persons' Services Act 1986* is not effective because the IDRPs powers are recommendatory and not binding on the Department of Human Services. The new legislation proposes use of the Complaints Mechanism to deal with dissatisfaction with individual plans. The outcome of the Complaint should bind the Department.

### **Recommendations 15**

*15. The legislation should contain principles to underpin a framework for individual planning.*

The Public Advocate supports the legislation containing principles to underpin the framework for individual planning. Whilst the principles mentioned in the discussion paper are seen as being important to the planning process the following are points of clarification:

- An explicit mention of the plan being developed with the person with the disability as far as practicable. This recommendation is made on the basis that a competent person with a disability can also refuse to have a plan.
- Where appropriate any advocates, family members and/or significant others with a demonstrated 'sufficient interest' should also be included. The reference in the discussion paper to the fact that planning "may" involve people or advocates who are important in the person's life, needs to be at the discretion of the person with the disability and not the individual or organisation responsible for developing the plan.

In addition there should be a principle which seeks to ensure that the planning process is not captive to service providers thereby limiting the plan and its delivery.

The two main problems with planning under the *Intellectually Disabled Persons' Services Act 1986* are –

- the failure to implement the plan;
- poor quality of services.

The *Report of Recommendations* paper does not address these problems.

## **Recommendations 16 & 17**

*16. An individual plan will be provided for people with an intellectual disability unless they request otherwise.*

*17. Other people with a disability may request access to an individual plan, which will form the basis of support provision.*

The limiting of automatic provision of a plan to people who have an intellectual disability does not take into account many others who have a disability who may not be able to exercise their rights for an individual plan. In particular people who have an acquired brain injury may not know they have a right to a plan on request. Accordingly, it is recommended that a plan will be provided to all people who are eligible under the legislation unless they make an informed decision to the contrary. Further, the Department of Human Services must (as a statement of its objectives) be obliged to ensure that people who have a disability are informed of their rights and the ways to exercise their rights, including the right to a plan.

The *Report of Recommendations* paper does not provide detail on what is involved in making individual plans, for example in relation to –

- timelines;
- consultation for the plan;
- services transcending the Victorian jurisdictional responsibilities under the CSTDA (eg: employment);
- review times and processes.

What is intended in this area should be provided in the legislation and policy and made public for comment.

The Public Advocate is concerned that the review mechanism is not spelt out as is currently done in the *Intellectually Disabled Persons' Services Act 1986*. Reviews must be attended to in a timely manner. Further the appeal right to a complaints mechanism within the Dept. of Human Services does not meet the requirement that the complaints mechanism be independent from that Department.

## ***Tenancy rights for people with a disability in community residential units***

### **Recommendation 18**

*18. The Residential Tenancies Act should be amended to enable community residential units to come within this Act.*

The Public Advocate welcomes this development. The recommendations do not provide a definition of a community residential unit and it is not clear what types of living arrangements will be covered by this change. The Public Advocate is aware of the development of new models of shared community living for people that differs from the home model. For example, where people have separate units and there is a separate office from where support staff provide assistance. These people should have tenancy rights but may not be caught by the traditional understanding of a CRU.

### **Recommendation 20**

*20. The Residential Tenancies Act should be amended to enable an owner to enter a resident's room for the purpose of providing support, where the owner is also the support provider.*

The Public Advocate considers this an important variation on the usual rights of people in rooming houses as they will apply in CRUs. Whilst the *Residential Tenancies Act 1997* does not govern the relationships between a non-owner/manager support agency and the tenant, it would be helpful if it were made clear on what basis such non-owner/manager support agencies could enter rooms to provide assistance when required.

### **Recommendation 21**

*21. The Residential Tenancies Act should be amended to include a notice to vacate that is specific to community residential units and relates to the provision of support.*

It would be helpful to examine the process that is contemplated by this recommendation. The Public Advocate considers it important that there be advocacy support for residents who are given a notice to vacate.

### ***Protecting privacy and managing information***

*22. The legislation should contain provisions covering the collection, use and disclosure of personal information about people with a disability receiving services and supports under the Act.*

*23. There should be penalty provisions for using information about a person with a disability in ways that contravene the Act.*

It is important that there not be unnecessary proliferation of legislation dealing with the same information leading to confusion as to what Act applies to what information. The preface to the recommendations suggest that specific legislation will make privacy requirements “clearer”, implying that they are not currently clear.

The Public Advocate considers that if there is a lack of clarity in relation to information privacy for people who have a disability under the *Health Records Act 2001* and the *Information Privacy Act 2000*, clarification should be sought through these Acts before embarking on a third regime of compliance. It is noted that under these Acts there are provisions for the issuing of guidelines.

The Public Advocate's office has recently discussed with the Health Services Commissioner and the Privacy Commissioner the exact powers of the authorised representatives of people who are unable to exercise their rights as set out in sections 64 of the *Information Privacy Act 2000* and section 85 of the *Health Records Act 2001*. For example, can an administrator exercise the role of the authorised representative in relation to health information? It is submitted that the current Acts are ambiguous and this should be resolved.

## *Money held on behalf of people with a disability*

In relation to people who will have tenancy rights, section 109 of the *Residential Tenancies Act 1997* provides:

If a rooming house owner charges an amount for services to a resident, the owner must—

- (a) provide the resident with a separate schedule of the amount relating to the services that the rooming house owner provides before the resident takes up residency of the room; and
- (b) if the resident uses any of those services, provide the resident with an itemised account showing the resident's individual use of the services.

This provision may also be used to facilitate accountability for a resident's money.

## **Chapter 6. Accountability of disability services and supports**

### *Provision of information to support users*

#### **Recommendations 27 and 28**

*27. The legislation should require support providers to provide specified information to support users.*

*28. Providers of residential support should be required to provide additional information to service users.*

It should be mandated that the service provider provide the service user with

- information regarding the service agreement between the user and the provider; and
- the service agreement between the Department funding the service and the service provider;
- or where the service user can quickly obtain this information from the service provider.

Agreements between service providers and government should not be governed by “commercial in confidence” exemptions to their disclosure to service users.

The recommendations themselves do not include the important statement set out in their preface

Support providers must take all reasonable steps to ensure that the information is provided in a form that is accessible and understandable to the person.

This is most important.

### *Improving the quality of disability services and supports*

#### **Recommendation 30**

*30. The legislation should enable disability support providers to be monitored for compliance with the standards.*

It is the role of the State government to monitor the quality of the services that it funds for people with a disability.

The quality of all the services to people with disabilities must be measured against the new disability standards. To monitor this effectively there needs to be an accreditation system and independent monitors that will allow services to be audited and validated in an active and regular way.

The new disability standards should facilitate a wide range of activities regarding providing quality services and also encourage further improvement. These activities should include:

- a focus on implementation of practice (rather than just writing about it), that facilitates a change in cultural practices, and promotes integration and inclusion
- training and supervision of staff

- prioritising and promoting the input of people with disabilities, and engaging independent advocacy support agencies that have a responsibility to ensure that the ‘voice of the person with a disability’ is heard

### *Disability Complaints System*

The Public Advocate does not consider the recommendation to establish a Disability Complaints Resolution Office to meet the recommendations of the Auditor General’s report (‘Services for people with an intellectual disability, November 2000) or the State Disability Plan to create an external complaints mechanism. The fundamental flaw is that this proposed Office would report to the Secretary of the Department of Human Services and, therefore, is not sufficiently independent.

The Public Advocate does not support the proposed Disability Complaints Resolution Office as:

- The complaints mechanism should be completely independent from any organisations which provide support and in particular the Department of Human Services given its role in both funding and providing disability services, given the conflict of interest. The mechanism should also not be attached administratively to the Department of Human Services. To do so would compromise the confidence of key stakeholders (people with disabilities, their advocates and their families) in its independence.
- The difficulties of the proposed Disability Complaints Resolution Office are not alleviated by the Ombudsman’s having oversight of its operation. Currently, all internal government complaints bodies are accountable to the Ombudsman in the way they respond to complaints. Consequently it would seem that this arrangement does not offer the external complaints mechanism any greater standing in the eyes of the community. Moreover this would do little to overcome the perceived conflict of interest.

The Public Advocate supports

- An external complaints mechanism that reports directly to Parliament on its activities each year.
- If the external complaints mechanism is to be co-located with another organisation, that organisation should be robust and viable with adequate infrastructure and have a justice and/or human rights orientation.
- In this regard, a possible location for the external complaints mechanism would be the Ombudsman. A specific section could be established within the Ombudsman’s office to investigate complaints in this area. In this context the powers given to the Ombudsman under this legislation would need to extend to all disability services (public, for profit, charitable, religious or community) to enable it to investigate and resolve complaints. This location would ensure the authority, independence, legitimacy and ongoing viability, of the external complaints mechanism as well as broaden the skills of the Ombudsman’s office to investigate complaints relating to people with a disability. This also helps reduce the potential for a confusing array of complaints bodies being created, potentially hampering access. The Public Advocate understands the experience of locating a complaints mechanism within the Ombudsman in New South Wales has proved more successful than a stand alone Complaints Commission.

- vi. The external complaints mechanism needs to be appropriately resourced to carry out its role and the funding source should also be carefully considered to ensure this does not compromise its independence.
- vii. The accessibility of the external complaints mechanism will need to be carefully considered together with appropriate promotion of its role and function to people with a disability, advocates, family, carers and services generally. Access to independent advocacy will be an important aspect of making the complaints mechanism accessible to some people with a disability.
- viii. As mentioned in the Public Advocate's previous submission, the external complaints mechanism must be reactive (individual complaint work) and proactive (preventative systemic work) in relation to complaints. In order to undertake these roles effectively the mechanism would need wide authority to undertake investigations, require the production of documents, call witnesses, visit work sites and report to Parliament.
- ix. The legislation should enable the Community Visitors Board (see section 61 of the *Intellectually Disabled Persons' Services Act 1986*) to refer matters to the external complaints mechanism. This relationship should be open and transparent.
- x. This external complaints mechanism should not be seen as replacing the responsibility of service providers to have clear processes in place to respond effectively to complaints.

## ***Community Visitors***

### **Recommendation 34**

*34. The legislation should enable the Community Visitors Board to refer matters reported by community visitors to other bodies as appropriate in the circumstances.*

The Community Visitors (CVs) already observe, monitor and report on a wide range of activities within disability accommodation. This role should be continued. The strength of the community visitors comes from their independence and common sense. This should be seen alongside and complementary to professional monitoring of services, and not a substitute for it. Monitoring also will involve service users, their families and advocates.

The recommendations are not clear how services are accredited and monitored. The Community Visitor role in monitoring must be set out in legislation to ensure that there is authorisation for the proper fulfillment of the role. This must canvass access to information and documentation for CVs to fulfill this role.

When a service is assessed for accreditation, the accreditation agency should be required to access CV reports on the service and have the option of discussing the service with CVs. Further, if a service is accredited, CVs would benefit from seeing the accreditation reports and the right to do this may have to be legislated in case exemption is sought on the basis of their being commercial-in-confidence or some other ground.

In relation to the complaints resolution body, the Community Visitors Board should have standing to make a complaint.

The legislation should have regard to the types of services CVs will be entitled to visit. This should be sufficiently flexible to take into account new services that may develop within the disability sector including new models of accommodation service.

### **Recommendations 35 & 36**

*35. Community visitors (or a representative of the Office of the Public Advocate) should be required to respond to a request to visit a person within seven days where requested to do so.*

*36. The Community Visitors Board should be able to refuse a request to visit a person with a disability living in a residential service in certain limited circumstances.*

The Public Advocate supports these recommendations.

### **Reviewable decisions**

#### **Recommendation 37**

*37. There should be internal review of the following administrative decisions:*

- *whether a person has a disability within the meaning of the Act*
- *the placement of a person in a residential institution*
- *the use of restrictive practices*
- *certain decisions relating to security residents.*

*38. There should be external review of the above administrative decisions by the Victorian Civil and Administrative Tribunal.*

The Public Advocate considers that the list of reviewable decisions is too limited.

In relation to people who have an intellectual disability receiving services under the *Intellectually Disabled Persons' Services Act 1986* the list means a significant diminution of their rights as it excludes review of individual plans. The Public Advocate supports an internal and external review of individual plans whether it be for people who have an intellectual disability or for any person who has a disability who exercises their right to a plan. VCAT must have the power to bind the Department with its decision in relation to a plan that it amends.

The recommendations lack sufficient detail to assess the fairness of time limits in relation to administrative decisions about eligibility, completion and review of individual plans. Time limits are crucial when a person is affected by not getting services and a failure to make a decision or a plan by a certain date should be reviewable.

The Public Advocate supports review by VCAT rather than another board or tribunal. There are significant advantages in having more than one person determine such matters and the breadth of people from various disciplines used in the IDRPs and the MHRB should continue through VCAT. The Public Advocate is aware that the former Guardianship and Administration Board also had multiple members and this practice declined when it became part of VCAT. It is submitted that the legislation should include multi-disciplinary membership of VCAT when it hears such matters.

## Chapter 7. Restrictive Interventions

### *The Office of the Senior Clinician*

#### **Recommendation 39**

*39. The legislation should provide for the establishment of an Office of the Senior Clinician.*

The role of the Office of Senior Clinician does not include authorising restraint and seclusion. It is noted in the State Disability Plan the Government committed itself to “develop an independent, open and transparent means of authorising, reviewing and regulating practices that restrict people’s rights” (Priority Strategy 3).

Where the person is unable to consent to restraint and seclusion it is necessary that there be authorisation for the practice which is independent from the service provider. In the past this authorisation was through meeting criteria in the legislation (other than in situations of an emergency). This was insufficient to guarantee the rights of people and protect them from abuse. The proposal that it can be authorised through a behaviour management plan which is itself authorised by an authorised program officer is not independent.

The view of this Office is consistent with recommendation 57 of the Victorian Law Reform Commission report *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care*:

*57. Where it is proposed that provision of services to a person with an intellectual disability may require the use of mechanical or chemical restraint and seclusion:*

- *a care plan must be prepared that indicates how the proposed form of restraint or seclusion will be used in managing the person’s behaviour;*
- *the care plan must indicate how the use of restraint or seclusion will benefit the person; and*
- *the care plan proposing use of these measures must be approved by the Office of Senior Clinician, who must be satisfied that the statutory criteria apply.*

The Office of Senior Clinician must be properly resourced to carry out its various functions.

The Public Advocate supports recommendation 9 and 10 of *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care*:

*9. An Office of Senior Clinician should be established as an independent statutory authority resourced by the Department of Human Services and reporting annually to the Minister for Community Services.*

*10. The Annual Report of the Office of Senior Clinician should be tabled in Parliament.*

The proposal that the Senior Clinician report directly to the Executive Director, Disability Services of the Department of Human Services is insufficient to satisfy the demand for scrutiny when people’s rights of freedom of movement are involved. The

Office of the Chief Psychiatrist is not analogous to that of the proposed Senior Clinician in that the Senior Clinician has functions specific to restrictive interventions on restraint, seclusion and compulsory treatment which the Chief Psychiatrist does not. In the case of the Chief Psychiatrist, an independent multi-member expert tribunal oversees restrictive interventions.

The Public Advocate considers the name “Senior Clinician” reflects the medical model of disability and another title should be sought.

### ***Restraint and seclusion in the new legislation***

#### **Criteria and procedures for restraint and seclusion**

The definition of chemical restraint to exclude medication given for the primary purpose of treating a person’s mental illness is not satisfactory. The exception is sensible if the person is subject to the involuntary provisions of the *Mental Health Act* 1986. If the person is being given such medication and

- they are not subject to the provisions of the *Mental Health Act* 1986 and
- the effect of the medication is to restrain their behaviour, and
- they are incapable of giving informed consent to the taking of medication,

this should be reported to the Office of Senior Clinician.

#### **Recommendation 42**

*42. The legislation should contain criteria providing that mechanical and chemical restraint and seclusion should only be used where it is:*

- *necessary to prevent a person from physically harming him or herself or any other person, or to prevent a person from destroying property in a way that will pose a risk of serious harm to themselves or others*
- *the least restrictive option*
- *included in a person’s behaviour management plan, which has been authorised by the authorised program officer.*

The Public Advocate supports the inclusion in legislation of statutory requirements regarding the use of restraint and seclusion as well as a provision that captures the requirements set out in recommendation 57 of *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care* regarding Care Plans:

*57. Where it is proposed that provision of services to a person with an intellectual disability may require the use of mechanical or chemical restraint and seclusion:*

- *a care plan must be prepared that indicates how the proposed form of restraint or seclusion will be used in managing the person’s behaviour;*
- *the care plan must indicate how the use of restraint or seclusion will benefit the person; and*
- *the care plan proposing use of these measures must be approved by the Office of Senior Clinician, who must be satisfied that the statutory criteria apply.*

#### **Recommendations 44**

*44. Support providers should provide specified information about the use of restraint and seclusion to the Office of the Senior Clinician.*

This recommendation does not specify how often a support provider should provide information to the Office of Senior Clinician. In the preface to this recommendation, a 12 month period is postulated. Under the *Intellectually Disabled Persons' Services Act* 1986 it is required monthly.

The Public Advocate supports monthly reports to the Office of Senior Clinician about the use of restraint and seclusion. The annual report is relevant to an assessment of the continuation of the practice, but if there is no information to check against the annual report, the Office of Senior Clinician will be captive to the accuracy of this one report.

#### **Recommendations 45**

*45. The Office of the Senior Clinician should have powers to investigate, monitor and impose conditions on the use of restraint and seclusion.*

The Public Advocate welcomes the inclusion of a power to investigate, to obtain information from support providers and to impose conditions, limitations or prohibitions on the use of restraint and seclusion. Many people who have a disability live at home with their families and may be subject to very restrictive practices. The Office of Senior Clinician should be empowered to investigate concerns regarding this type of use of restraint and seclusion.

Community Visitors are authorized under the *Intellectually Disabled Persons' Services Act* 1986 to inquire into the use of restraint and seclusion. This power should be retained in the new legislation.

#### **Recommendation 47**

*47. The legislation should require that prior to a person being subject to restraint and seclusion, he or she must be provided with an independent person to assist them to understand and exercise their rights.*

The Public Advocate supports this proposal to assist people to understand what it means to be restrained or secluded. However, there will be cases where, despite the best efforts of the independent person, a person is unable to understand the proposals for their restraint and seclusion. This is another reason why the Office of the Senior Clinician must authorise all instances of the practice if it is to proceed.

The Office of the Public Advocate manages the Independent Third Person Program (ITP Program) in relation to police investigations. From our experience of managing the ITP Program, the development of a similar model to apply to the planning process for the provision of restraint and seclusion has significant resource implications and consideration must be given as to how the proposed program of independent persons could be funded, structured and operated.

#### **Other restrictive practices**

It is important that the role of the Senior Clinician include checking to ensure that people who would meet the criteria for compulsory treatment are not re-assessed (for the convenience of service providers) so that they are regarded as simply needing restraint and seclusion. It should not be possible for a person who is a risk to himself

and others to be reclassified to be a risk only to himself and thereby avoid the scrutiny of the process of compulsory treatment.

## ***Compulsory Treatment***

### **Recommendation 49**

*49. The compulsory treatment of people who are involved in the criminal justice system should only occur in prescribed facilities.*

It should be clarified that the expression “in the criminal justice system” applies only to those who are subject to a court order under the criminal justice system. Compulsory treatment cannot be part of a diversion program.

### **Recommendations 52 and 53**

*52. The compulsory treatment of people who continue to receive treatment in a prescribed facility after their court order has expired should be regulated under legislation.*

*53. The compulsory treatment of people who are living in a restrictive environment because there is concern they might pose a serious risk of harm to members of the community should be regulated under legislation.*

It is difficult to comment on the recommendations as so little detail is provided. The Public Advocate reiterates the importance of comprehensive legislation in this area and looks forward to commenting on the detail.

The Public Advocate supports the recommendations of the Victorian Law Reform Commission in the *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care* regarding detention orders and specifically refers to –

- Recommendations 18 to 20 where the Senior Clinician engages a multi-disciplinary panel to assess the person for providing a report to VCAT;
- Recommendation 21 where the panel that orders detention includes either a Supreme or County Court judge and at least one member from another discipline related to disability;
- Recommendation 24 regarding advocacy for people facing detention orders; and
- Recommendation 30 authorising reassessment in 6 months of the initial order. However, the Public Advocate considers VCAT should be empowered to set the period of reassessment up to a maximum of 12 months.

The Public Advocate considers that so long as a detention order is therapeutic, a series of orders should not be limited to a maximum five year time span. The Public Advocate is concerned that a five year period could result in a reversion to the use of guardianship for civil detention of persons after the end of that period.

The Public Advocate supports a provision for interim detention orders in emergencies.

Thursday, December 16, 2004